High Impact Complex Drinkers Pilot 2016, Key Messages and Future Directions.

Surrey County Council
Public Health

SURREY

Key Messages

Introduction

- High Impact complex drinkers exist in every locality, these individuals' alcohol use and associated lifestyle contributes to a pattern of more **frequent contact** with a **range of frontline services** including NHS (A&E departments) and Police (repeat callers, hospital visits and police call outs).
- This client group is **highly diverse**, characterised by the **complexity of their needs**, multi-morbidity and **exclusion** from society.
- They also face a range of different social circumstances, which could include being homeless or having temporary accommodation, involvement in the criminal justice system, commonly experiencing mental health problems, facing financial difficulties and lacking in social capital or support networks.
- The complexity of these health and social care needs often acts as a **barrier** to engagement, for example the organisation of appointments for people with no fixed abode or stable contact information can become problematic.
- Further for those with complex needs the threshold of **engagement** required to maintain treatment or active participation in services is **beyond their level of motivation**. This results in clients being frequently **socially excluded** and they can become **isolated from services**, which may then classify them as 'treatment resistant', 'intentionally homeless' or 'hard to engage'.
- Specifically related to Substance Misuse services, evidence suggests that these clients respond best to an assertive approach (taking the service to the client), which is not time limited, and which accepts that change may be more gradual and faltering.
- However, for this to be effective **a fully integrated response is required**, involving a number of services working to shared goals and by sharing information.

Surrey's Position

- In Surrey prior to 2014 there was no service element or joint working arrangement which enabled services to work in this way, therefore Public Health joined with Alcohol Concerns Blue Light Project to carry out modelling to estimate the number of clients in Surrey who might meet the high impact complex drinkers criteria.
- The core aims of the Blue Light project are to develop responses that require minimal investment by:
    - Using existing resources more effectively;
    - Achieving the greatest impact by bringing organisations together and refocusing what they do;
    - Building bridges with partners like the Police, housing and social care.

Key Findings from other areas

- Findings from other areas following this model have been positive;
    - Lincolnshire have prioritised clients working with the Police and six

months into service delivery have seen a 30% reduction in Police incidents.

- Nottinghamshire developed an Alcohol Care Team within a hospital, investing between £160k and £180k; in their second year the service reported healthcare savings of £360k.
- Salford also developed an Alcohol Care Team. An investment of £300k released savings of £606k in healthcare within the second year.

Modelling in Surrey

- Modelling carried out in Surrey, in partnership with Alcohol Concern in 2014, identifies over 2000 clients, from a range of different services / partner forums (MARACs, Police, A+E etc.) who are likely to meet the criteria of the "High Impact Complex Drinker" pilot.
- However, it is highly likely that these estimates will double-count clients as they are known to more than one service, therefore a conservative estimate of 15-20% of these figures would still present a level of need of between **300-400 clients.**
- It is estimated that the total cost of these clients is **£55,664,693.**

Pilot Evaluation

- This modelling led to a pilot being carried out in **Guildford, Waverly and Woking**. Where **two community workers** were employed by the Tier 3 substance misuse service.
- The Blue Light model places emphasis on these community workers supporting a **joint response (see Figure 2)**.
- The primary functions of these workers were:
    - To provide assertive alcohol outreach for those who find it difficult to engage with substance misuse treatment services and to support their access to a variety of support networks or services;
    - To plan and organise activities with service users according to their care plan and liaison with other key workers.
- The surrey Pilot had **24 referrals**, from these **14 were suitable** for the service and via continued support **9 of these progressed to Tier 3 or 4 treatment**.
- For 9 clients a **cost analysis** was carried out, tracking within the A&E department showed across 18 months an estimated cost of **£216,403.20 - £281,757.60**.
- Modelling assumptions were conducted in partnership with the RSCH Alcohol Liaison Nurse. These included ambulance call-outs and transfers, attendance at A+E, admissions, bed days and unplanned non specialist detoxification but did not include other further medical interventions delivered, which were administered for the presented issue requiring medical attention following the individual presenting at A+E.

- Where the referral date could be identified this allowed for a pre- and post-analysis. Results from analysis shows an expected **1:4 (£) return on investment**; if two case workers work at full capacity (rolling caseload of 36 clients) across a **12 month period.**
- Therefore a further investment of £75,000 HICD investment in Surrey is expected to **reduce health costs from £612,125 to £303,151**.
- The pilot was unable to track the impact on the criminal justice and community safety. Evidence suggests that savings to the criminal justice system would be between 50% and 100% to those of the health care system.
- When looking at the average number of attendances, admissions and bed days, this cost analysis also showed:
    - Average number of **attendances** for all clients across 18 months was 33. For pre- and post- intervention this reduced from 29 to 21 per client respectively;
    - Average number of **admissions** for all clients across 18 months was 5. For pre- and post- intervention this reduced from 5 to 2 per client respectively;
    - Average number of **bed days** per stay across the 18 months was 5 nights. When this is looked at pre- and post- intervention this reduces from 5 nights to 2 nights.
- Feedback from core services suggests that the **two primary barriers** are access to mental health services **(dual diagnosis)** and access to suitable **housing** / accommodation.

Opportunities and future delivery.

- The vision for High Impact Complex Drinkers is to develop **an integrated treatment response** that offers measurable benefits to individual service users and the services they come into contact with. This service could:
    - be holistic and client centred;
    - understand the complexity of these clients;
    - focus on sustained (rather than time limited) approach;
    - reflects and adapts to a client's needs. Understanding that this will take time and may face relapse.
- Development of such a service seeks **system-wide change** to understanding and de-stigmatisation of these clients.
- Services should recognise and understand the demands partner services are working to and should manage each other's expectations so a clear joint care plan can be offered to the client.
- This may require a robust information sharing protocol and tool. Any future service should aim to understand the barriers to developing such a protocol and tool and how this might be overcome in the future, learning from other transformational and integration work across Surrey and our neighbours.
- There are a number of **other complex needs or priority services** which are currently being delivered in Surrey, the HICD service should link with these

services to improve partnership working and where possible contribute to the joint care plan for these clients, thus improving outcomes including:
    - High Intensity Mental Health Users Project;
    - Homelessness Alliance (specifically contributing to the recommendations of the 2016 Homelessness Audit);
    - Transforming Women's Justice.
- Strategically, using resources across CCG's and the County Council, work should be done to **build on and improve partnership working across dual diagnosis.**
- Working with the Police and Crime Commissioners Office, Public Health will lead on the commissioning of an **extensive two year evaluation project (expected to commence Q4 2016/2017)**. This service will:
    - Sit alongside the aforementioned complex needs services;
    - expand to work county wide with **3 priority areas** (Guildford or Woking, Reigate and Banstead and Spelthorne) and developing pathways for engaging **geographically excluded** residents who are unlikely to be engaging with services until in crisis;
    - aim to target between 100-120 clients;
    - use Community Incident Action Groups, Police Teams and A&E departments as key referral routes;
    - improve partnership working with the Adult Safeguarding Board;
    - improve working across substance misuse and mental health services, working with the Crisis Concordat.
- Be guided by a **strategic steering group** which can support across front line services (housing managers, police, substance misuse services, social care commissioners, mental health commissioners etc.)
- This evaluation should consider the viability of carrying out an in-depth **data - linking exercise** so an **economic evaluation** can be carried out across the Health and Social Care system and Criminal Justice System.

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